



07 07 2005

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To whom it may concern. Read my print! Listen to my lips! Don't mess with my medical benefits at McChord AFB, WA. How do you figure money will be saved by shutting down the 62 Medical Group? It's a new facility. The patients seen there will probably go to Madigan to be treated. Madgan doesn't have the staff to take on new patients. I know this because my mother is treated there. I like my medical from the 62 MG. I see the doctor that I'm assigned to or his PA. Most of the time after I've been seen I get my prescriptions within 30 minutes. If lab or x-ray work is needed there is usually little or no wait. At immunizations a person is usually seen promptly. There are very few problems with scheduling any appointment with any of the providers.

If McChord's patients are transferred to Madigan there is no way the existing staff could handle the new workload. More personnel would need to be added. For me to be seen at Madigan on a regular basis is an injustice to the treatment that I have now! My mother is seen there on a regular basis. During the years she has been treated there she has only seen her doctor twice. Every time she sees a different doctor they change or modify her treatment and or prescriptions. She is rarely seen on time at the internal medical clinic. She always has to wait several minutes for lab work, which is, required every visit. A person can expect a 2-hour wait at the Madigan pharmacy and most of the time there is a wait at the drive through. The drive through prescriptions has to be called in at least 3 days ahead of time. Recently I had an appointment at the urology clinic, it took 1 hr to be seen. I'm still waiting for my biopsy results and it's been 2 weeks. Madigan couldn't see me earlier this year for a sigmoidoscopy and I had to go downtown. It cost me \$25 for co-pays.

You tell me how money will be saved by closing the 62 MG! Let me ask you this? How would you like to see a different provider each time you needed medical treatment? Would you like to take a whole day off from work or your daily schedule to seek treatment? There are some things Madigan does right such as saving lives however routine treatment is a quagmire.

  
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05312005

25 May 2005

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Military medical care at both McChord Clinic and Madigan hospital is greatly over-burdened and verges on inadequate. I have personal experience at both facilities. I'm a retired USAF officer residing in Steilacoom, and enrolled in Tricare Prime at McChord AFB Clinic.

The DOD BRAC Medical Vol X goals appear to be:

1. Support "war-fighters". It appears this is to be done by outsourcing more (possibly all) non-"war-fighter" TRICARE PRIME dependent and retired patients to Tricare's civilian network. Tricare Prime, with its assignment to Military Treatment Facilities (MTFs) is now re-named the "Direct Care System." Tricare Prime is transformed to essentially what Tricare STANDARD is now. This is akin to corporations cutting employees with burdensome "legacy" costs.
2. Enhance "joint-ness" through co-location and consolidation. Joint operations means just that. It does not equate to cutting staffing...unless and only unless, operations are over-manned. This is not the case at either facility.
3. Cut military medical costs. This appears to entail choosing to man military medical facilities solely to warfighter care. Unfortunately, all service members are no longer single. This is actually cutting funding, not cutting costs. Costs are growing exponentially because of wars in Iraq and Afghanistan, a largely married military, growing retired populations and the addition of Reserve and Guard personnel and their families to the system.

Employees at both McChord and Ft Lewis may feel constrained to contact you and ask for help. So, having talked to many in both facilities, I know military and civilians at both the clinic and hospital are dumb-founded that anyone could consider either under-utilized. Reminds me of the attempted closure of American Lake VA hospital. Too many patients, too long waits (years) to be seen...obviously must mean under-utilization.

Currently, Fort Lewis is home to Madigan Hospital and at least one Clinic on its North Fort area.

Currently, McChord Clinic and Madigan already work together. If "consolidation" treating each others' patients, Army and Air Force, it already exists. If it means placing Air Force management/command structure under that of Ft Lewis, that is doable, and if made "joint duty" would be welcomed.

McChord's Clinic was built in 2000 and Madigan in 1996. Both are near state of the art and both are over-crowded.

McChord Clinic is manned with 215 military and 29 civilians.

Currently, Fort Lewis' Madigan Hospital Tricare Prime patients wait 6+ weeks to see their primary care doctors. I don't know the wait for its Clinic at North Fort.

My personal experience has been a non-emergency wait of 2.5 to 4 weeks for an appointment at McChord.

Madigan is over-burdened at all levels. McChord is less so, but inability to be seen when seriously ill, still forces active duty, retired and dependents to wait all day at Madigan's Acute Care/Emergency Room. This burdens that hospital's emergency areas with non-emergency patients who are just sick enough, they can't wait weeks. It's the norm for both Army and Air Force active, retired and dependents with serious, but non-emergency ills to seek treatment at the Acute Care clinic at Madigan because appointments are unavailable at either McChord or Madigan primary care doctors for several weeks. THIS IS CURRENT MILITARY MEDICAL CARE.

Many doctors are separating, deployed, TDY or retiring as soon as allowed.

Referral to specialists at Madigan by either McChord or Madigan primary care, often means automatic referral to civilian Tricare network due to lack of appointments for months at Madigan.

My referrals have been to ophthalmology and dermatology. I can get in to see those specialists at Madigan ONLY IF I have already been seen and am a patient in the specialty. Luckily, I was for ophthalmology. Not so Dermatology, which means automatic referral to a non-military specialist and a 5-8 week wait with a co-pay. (Madigan Hospital had only one Dermatologist on staff for a six month stretch. It now has two dermatologists.)

Madigan's pharmacy is huge. Though having drive through windows, service entails LONG waits for meds newly prescribed. After just one visit, I never used that pharmacy again. I ask that prescriptions be written for McChord pharmacy. It takes less time to drive from treatment at Madigan to McChord to pick up meds than to wait at Madigan. McChord Pharmacy averages ½ hour to 1.5 hours for newly prescribed meds. Both pharmacies do massive phone in refills, to be picked up in two working days.

#### QUESTIONS:

1. How was the term, "UNDER-UTILIZED" decided and applied to McChord Clinic? Was it actual patient load or RVUs from 2002? If so, please ask Clinic Commander which measure is more accurate.
2. Is the definition of "under-utilized" a wait of MORE than 4 weeks to get an appointment to see your primary care doctor?
3. Why is McChord Clinic (possibly) to be closed, and not Fort Lewis' North Fort Clinic? Is this done for ideological goals or to better serve patients?
4. Is McChord's Clinic is to remain as is, but management consolidated under Madigan's? Is patient care going to become modeled upon that of Madigan's where seeing your primary care doctor is RARE? Does being treated by a doctor who has never seen you, and who may not have had a chance between patients to read your record, equate to "adequate" utilization? At McChord, patients usually see their assigned doctor, who recognizes them and recalls some history.
4. If McChord Clinic manning is 225 military and 29 civilian, where are the cuts to be? DOD Medical paper shows a combined 169. It also shows Ft Lewis/Madigan MEDICAL GAIN of military=185 & civilian=46 (total=233)
5. Was the 10 bed inpatient criterion applied to McChord's outpatient clinic?
6. What is ADEQUATE care/ population of Tricare Network (within 40 mile radius of each facility)?

The DOD paper states (page 2): "Medical JCSG used the responses from the installations...to perform a capacity analysis and review surge requirements." The region around both McChord and Ft Lewis has a huge and growing active duty plus dependent, reserve and guard plus dependent, retired plus dependent population. The surrounding Tricare civilian network is inadequate as is, with appointments available only after 2+ months, for dermatology in particular. How can it REPLACE military facility capacity transfers after staff cuts?

**Personal story:** I had sudden onset of blurred vision, near and distance Feb 2002. Previously my distance vision was 20/15. I wore reading glasses with 1.5 correction (simple magnification)

It took me 3 months to see my doctor to get a referral to Madigan Ophthalmology. I was diagnosed with an ERM (epi-retinal membrane). Delay for surgery was 3 months. I'd met a surgeon on the UW staff, so I taught myself how to get Tricare approval for surgery at UW.

Vision remained blurred and worsened. It was not due to the ERM. I began my own research. Meantime, I was referred to a civilian cornea specialist (Madigan's were all deployed or TDY). That specialist diagnosed "Keratoconus." Serious and treated with hard contact lenses or with CORNEA TRANSPLANTS.

More personal research. I needed to prove the cause of corneal swelling. I went to technicians at both the civilian cornea specialist and Madigan Ophthalmology to get monthly topographies. I graphed the results comparing each to when I was taking oral antibiotics and not. Then I found an article in Cornea: "Pseudo-Keratoconus from Ocular Rosacea."

I realized I needed a Dermatologist referral to get that diagnosis, just to be listened to in ophthalmology. No dermatologist appointments available at Madigan, so I drove to VA Seattle. Got the diagnosis and am fine now...taking oral antibiotics, and cleaning the eyelash follicles multiple times daily. Imagine if I'd had a transplant with ocular rosacea's inflammation and infection.

**POINT:** Civilian doctors refused corneal topographies after three times. Madigan did not. The difference is equipment available and cost of that equipment.

Yet, treatment at military medical facilities according to this DOD BRAC medical paper is called "Direct Care" and "war-fighter" only. If that had been what I had from Feb. 2002 to Dec 2003. I'd now be blind.

What is happening is a quiet cutting of medical care to active and retired military. This administration speaks of honoring the military, yet has annually tried to cut VA and military funding across the board. I suppose both are examples of what is now referred to as the "welfare state."

I have a brain, am persistent and curious. So I've gotten treatment despite barriers. Most patients give up. Please prevent McChord Clinic's closure or downsizing of its physician staff.

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